STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155307	A. BUILDING 00 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE HEALTH CARE	7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00093249 completed on July 18, 2011. This visit was in conjunction with a PSR to the Recertification and State Licensure Survey completed on June 27, 2011. Complaint IN00093249-Not corrected. Dates of survey: August 9 & 10, 2011 Facility number: 000204 Provider number: 155307 Aim number: 100284910 Survey team: Lara Richards, R.N., T.C. Heather Tuttle, R.N. Kathleen (Kitty) Vargas, R.N. Census bed type: SNF/NF: 94 Total: 94 Census payor type: Medicare: 23 Medicaid: 56 Other: 15 Total: 94 Sample: 13	F0000	Preparation and implementation of this plan of correction does not constitute admission or agreement by Towne Centre Health Care of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 8-10-2011. Towne Centre Health Care specifically reserves the rights to move to strike or exclude this document as evidence in any civil, administrative, and criminal action not related directly to the licensing and/or certification of this facility or provider. Note: Deficiency was cited on an incident which had been self reported by the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2. Quality review 8/12/11 by Suzanne Williams, RN			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement its policy and procedures for abuse prevention and reporting related to the lack of Social Service assessments of psychosocial needs following an alleged incident of abuse for 1 of 3 residents reviewed for allegations of abuse in a sample of 13. (Resident #B) Findings include: The record for Resident #B was reviewed on 8/10/11 at 9:30 a.m. The resident had diagnoses, that included, but were not limited to, dementia and anxiety. There was an entry in the Nurse's Notes dated 8/2/11 at 6:30 (no a.m. or p.m. indicated) that indicated, "While staff was caring for resident in (room number listed), it was alleged they heard what	F0226	F226 1) Resident B was interviewed and has no anxiety when her daughter visits. Resident B daughter no longer requiring supervised visits per Care Plan with son who is POA and dtr-in-law. 2) No other resident were affected. Social Service staff were in-serviced on documentation requirements and the need to document the resident's psychosocial needs following any allegation of abuse. 3) Social Service Director has been in-serviced on documentation requirements 8-11-11 and 8-17-11 for Social Service Designee. The Administrator will review Social Service notes prior to proving required 5 day follow up as part of the Abuse protocol to assure the documentation is present. 4) Administrator will report to the monthly QA Committee the findings	08/24/2011

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	sounded like the resident in (bed "A" of this room number) being struck by a visiting family member this afternoon, while resident was in bed." The "Facility Incident Reporting Form," dated 8/2/11, was provided by the Administrator on 8/10/11 at 9:00 a.m. There was an investigation into the alleged abuse of the resident. It was determined the family member involved in the incident was to have supervised visits with the resident when in the facility. The family member was the resident's daughter-in-law. Interview with the Administrator on 8/10/11 at 11:10 a.m., indicated the resident's daughter-in-law had been visiting the resident since the incident. She also indicated the visits were supervised. Review of the Social Service Progress Notes, indicated there was an entry dated 7/21/11 at 3:30 p.m. The entry indicated, "Attempted interview with resident but does not speak English and appears to understand very little . . ." There were no additional entries in the Social Service Progress Notes. The policy titled "Abuse Prevention and Reporting Policy and Procedure," dated		from the chart review, for any further recommendations. 5) 8-25-11.	

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	9/21/10, was provided by the Administrator on 8/9/11 at 11:20 a.m. She indicated the policy was current. The policy indicated under the section titled "Protection": "Social Services is responsible for visiting the residents who have experienced an abuse incident to assess their psychosocial needs and develop interventions to address identified needs." There was no documentation in the Social Service Progress Notes that assessments of the resident's psychosocial needs had been completed. There was no assessment of any signs or lack of signs of distress, fear, or mood changes observed for the resident. There was no documentation in the record of the resident having supervised visits from the family member involved in the incident. There were no assessments of the resident's moods or behaviors during any of the supervised visits with the daughter-in-law. The Social Service Director was interviewed on 8/10/11 at 10:40 a.m. She indicated there was no documentation in the record related to the assessment of the resident's psychosocial needs following the alleged incident of abuse by a family member.			

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	Interview with the Administrator on 8/10/11 at 11:10 a.m., indicated the abuse policy was not followed related to the lack of documentation of the resident's assessment of her psychosocial needs. She indicated the Social Service Director should have assessed the resident and documented the assessment after the incident was reported. She also indicated the resident's reaction to the supervised visits should have been assessed and documented by the Social Service Director. This deficiency was cited on 7/18/11. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint IN00093249. 3.1-28(a)			